

		FOR OHF USE					

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**2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)**

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0025460</u> Facility Name: <u>FOREST VILLA</u> Address: <u>6840 W. TOUHY AVE.</u> <u>NILES</u> <u>60648</u> <div style="display: flex; justify-content: space-around; width: 100%;"> Number City Zip Code </div> County: <u>COOK</u> Telephone Number: <u>(847)647-8994</u> Fax # <u>(847)647-0500</u> IDPA ID Number: <u>36-3077541</u> Date of Initial License for Current Owners: <u>07/01/80</u> Type of Ownership: <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </div> <div> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </div> <div> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </div> </div>	
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In the event there are further questions about this report, please contact:
Name BOB KAGDA **Telephone Number:** (847) 675-3585

DPA 3745 (N-4-99)

IL478-2471

Print Preview

Facility Name & ID Number FOREST VILLA# 0025460 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>57</u>	Skilled (SNF)	<u>57</u>	<u>20,862</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>155</u>	Intermediate (ICF)	<u>155</u>	<u>56,730</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>212</u>	TOTALS	<u>212</u>	<u>77,592</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>6,138</u>	<u>1,375</u>	<u>7,115</u>	<u>14,628</u>	8
9	SNF/PED					9
10	ICF	<u>43,642</u>	<u>9,207</u>		<u>52,849</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>49,780</u>	<u>10,582</u>	<u>7,115</u>	<u>67,477</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4 86.96%)

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NONEF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 07/01/80

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 07/01/80 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 22 and days of care provided 5016Medicare Intermediary ADMINASTAR FEDERAL OF INDIANA

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL ☒ CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number FOREST VILLA # 0025460 Report Period Beginning: 01/01/2000 Ending: 12/31/2000
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	301,037	44,298	13,700	359,035		359,035	0	359,035		1
2	Food Purchase		302,258		302,258		302,258	0	302,258		2
3	Housekeeping	268,454	69,655	0	338,109		338,109	0	338,109		3
4	Laundry	74,616	33,996	5,793	114,405		114,405	0	114,405		4
5	Heat and Other Utilities			154,784	154,784		154,784	0	154,784		5
6	Maintenance	133,453		107,384	240,837		240,837	(3,255)	237,582		6
7	Other (specify):*			26,225	26,225		26,225	0	26,225		7
8	TOTAL General Services	777,560	450,207	307,886	1,535,653		1,535,653	(3,255)	1,532,398		8
	B. Health Care and Programs										
9	Medical Director			4,400	4,400		4,400	0	4,400		9
10	Nursing and Medical Records	2,454,329	106,466	7,023	2,567,818		2,567,818	0	2,567,818		10
10a	Therapy	257,761	5,097	20,191	283,049		283,049	0	283,049		10a
11	Activities	150,111	5,772	950	156,833		156,833	0	156,833		11
12	Social Services	199,939		4,351	204,290		204,290	0	204,290		12
13	Nurse Aide Training			0				0			13
14	Program Transportation			0				0			14
15	Other (specify):*							0			15
16	TOTAL Health Care and Progra	3,062,140	117,335	36,915	3,216,390		3,216,390		3,216,390		16
	C. General Administration										
17	Administrative	0		832,628	832,628		832,628	(652,014)	180,614		17
18	Directors Fees			0				0			18
19	Professional Services			106,196	106,196		106,196	4,231	110,427		19
20	Dues, Fees, Subscriptions & Promotions			72,475	72,475		72,475	(22,367)	50,108		20
21	Clerical & General Office Expense	114,697	70,970	70,995	256,662		256,662	205,756	462,418		21
22	Employee Benefits & Payroll Taxes			438,892	438,892		438,892	0	438,892		22
23	Inservice Training & Education			7,485	7,485		7,485	0	7,485		23
24	Travel and Seminar			0				1,645	1,645		24
25	Other Admin. Staff Transportation			4,616	4,616		4,616	4,427	9,043		25
26	Insurance-Prop.Liab.Malpractice			131,562	131,562		131,562	0	131,562		26
27	Other (specify):*			228,936	228,936		228,936	(198,384)	30,552		27
28	TOTAL General Administration	114,697	70,970	1,893,785	2,079,452		2,079,452	(656,706)	1,422,746		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,954,397	638,512	2,238,586	6,831,495		6,831,495	(659,961)	6,171,534		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number **FOREST VILLA**

0025460

Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			121,961	121,961		121,961	68,784	190,745		30
31	Amortization of Pre-Op. & Org.							0			31
32	Interest			74,837	74,837		74,837	47,632	122,469		32
33	Real Estate Taxes			211,975	211,975		211,975	0	211,975		33
34	Rent-Facility & Grounds			603,948	603,948		603,948	(603,948)			34
35	Rent-Equipment & Vehicles			28,815	28,815		28,815	6,796	35,611		35
36	Other (specify):* amort-comp.soft			3,189	3,189		3,189	0	3,189		36
37	TOTAL Ownership			1,044,725	1,044,725		1,044,725	(480,736)	563,989		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation							0			38
39	Ancillary Service Centers		204,235	54,706	258,941		258,941	0	258,941		39
40	Barber and Beauty Shops							0			40
41	Coffee and Gift Shops							0			41
42	Provider Participation Fee			116,388	116,388		116,388	0	116,388		42
43	Other (specify):*							0			43
44	TOTAL Special Cost Centers		204,235	171,094	375,329		375,329		375,329		44
45	GRAND TOTAL COST										
	(sum of lines 29, 37 & 44)	3,954,397	842,747	3,454,405	8,251,549	0	8,251,549	(1,140,697)	7,110,852		45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

STATE OF ILLINOIS

Page 5

Facility Name & ID Number **FOREST VILLA**

0025460

Report Period Beginning: **01/01/2000**

Ending: **2/31/2000**

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1 Amount	2 Refer- ence	3 OHF USE ONLY	
	NON-ALLOWABLE EXPENSES				
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program:				3
4	Non-Patient Meals		2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients		10		7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation	(7,202)	30		9
10	Interest and Other Investment Income	0	32		10
11	Discounts, Allowances, Rebates & Refunds		2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties		21		18
19	Entertainment	0	20		19
20	Contributions	(4,000)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals		26		23
24	Bad Debt	(228,936)	27		24
25	Fund Raising, Advertising and Promotional	(18,367)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees		13		27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule DEFERRED MAINT XIX-H	(3,255)	6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (261,760)		\$	30

OHF USE ONLY

48		49		50		51		52	
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B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(878,937)	SCHED	34
35	Other- Attach Schedule	0	TACHED	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (878,937)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ #####		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference
38	Medically Necessary Transport		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44	Exceptional Care Program		X		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

Print Preview

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.

IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary A

Facility Name & ID Numb FOREST VILLA

0025460 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary
A

Operating Expenses		PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0 1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0 2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0 3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0 4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0 5
6	Maintenance	(3,255)	0	0	0	0	0	0	0	0	0	0	(3,255) 6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 7
8	TOTAL General Services	(3,255)	0	0	0	0	0	0	0	0	0	0	(3,255) 8
B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0 9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0 10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0 10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0 11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0 12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0 13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0 14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 15
16	TOTAL Health Care and Program	0	0	0	0	0	0	0	0	0	0	0	0 16
C. General Administration													
17	Administrative	0	(652,014)	0	0	0	0	0	0	0	0	0	(652,014) 17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0 18
19	Professional Services	0	4,231	0	0	0	0	0	0	0	0	0	4,231 19
20	Fees, Subscriptions & Promotions	(22,367)	0	0	0	0	0	0	0	0	0	0	(22,367) 20
21	Clerical & General Office Expenses	0	205,756	0	0	0	0	0	0	0	0	0	205,756 21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0 22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0 23
24	Travel and Seminar	0	1,645	0	0	0	0	0	0	0	0	0	1,645 24
25	Other Admin. Staff Transportation	0	4,427	0	0	0	0	0	0	0	0	0	4,427 25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0 26
27	Other (specify):*	(228,936)	30,552	0	0	0	0	0	0	0	0	0	(198,384) 27
28	TOTAL General Administration	(251,303)	(405,403)	0	0	0	0	0	0	0	0	0	(656,706) 28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(254,558)	(405,403)	0	0	0	0	0	0	0	0	0	(659,961) 29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FOREST VILLA

0025460

Report Period Beginning:

01/01/2000 Ending:

12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary
B

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(7,202)	3,643	72,343	0	0	0	0	0	0	0	0	68,784	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	47,632	0	0	0	0	0	0	0	0	47,632	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(603,948)	0	0	0	0	0	0	0	0	(603,948)	34
35	Rent-Equipment & Vehicles	0	6,796	0	0	0	0	0	0	0	0	0	6,796	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(7,202)	10,439	(483,973)	0	0	0	0	0	0	0	0	(480,736)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(261,760)	(394,964)	(483,973)	0	0	0	0	0	0	0	0	(1,140,697)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	34 RENT	\$ 603,948			\$	(603,948)
16	V	30 DEPRECIATION		6840 W. TOUHY	100.00%	72,343	72,343
17	V	32 INTEREST		6840 W. TOUHY	100.00%	47,632	47,632
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 603,948			\$ 119,975 \$ *	(483,973)

Sum_6A

-603948
72343
47632

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6B

Facility Name & ID Number FOREST VILLA

0025460

Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6B

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6C

Facility Name & ID Number FOREST VILLA

0025460

Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6C

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Facility Name & ID Number **FOREST VILLA**# **0025460**

Report Period Beginning: 01/01/2000

Ending:

12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ARNOLD KAPLAN								\$		1
2	Total allowable compensation for cost report from Family CARE LTD is					SEE ATTACHED		SALARY	47,614	17-8	2
3											3
4											4
5	MICHAEL KAPLAN					50	100.00				5
6	Total allowable compensation for cost report from Family CARE LTD is							SALARY	133,000	17-8	6
7											7
8	ROBERT KAPLAN										8
9	Total allowable compensation for cost report from Family CARE LTD is					SEE ATTACHED		SALARY	46,909	21-8	9
10											10
11											11
12											12
13								TOTAL	\$ 227,523		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees)
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Print Preview

| the name(s)
PORTS.

Facility Name & ID Number **FOREST VILLA**# **0025460** Report Period Beginning: **01/01/2000**Ending: **1/31/2000**

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8D

Show Pgs 8E thru 8I

Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization **FAMILY CARE MANAGEMENT**Street Address **4840 W. TOUHY**City / State / Zip Code **NILES, IL 60648**Phone Number **(847)647-8994**Fax Number **(847)647-0500**

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATOR			\$	\$		\$ 133,000	1
2	17	OFFICER SALARY	RESIDENT DAYS	4	135,000	135,000	67,477	47,614	2
3	19	PROFESSIONAL FEES	RESIDENT DAYS	4	11,995		67,477	4,231	3
4	21	CLERICAL						35,400	4
5	21	CLERICAL	RESIDENT DAYS	4	483,009	320,553	67,477	170,356	5
6	24	INSERVICE SEMINAR						1,645	6
7	27	PAYROLL TAXES						9,360	7
8	27	EMPLOYEE BENIFITS	RESIDENT DAYS	4	60,086		67,477	21,192	8
9	25	AUTO EXPENSE	RESIDENT DAYS	4	12,551		67,477	4,427	9
10	30	DEPRCIATION	RESIDENT DAYS	4	10,330		67,477	3,643	10
11	35	OFFICE RENT	RESIDENT DAYS	4	19,270		67,477	6,796	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 732,241	\$ 455,553		\$ 437,664	25

Print Preview

Facility Name & ID Number **FOREST VILLA**# **0025460** Report Period Beginning: **01/01/2000**Ending: **12/31/2000**

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization **6840 PARTNERSHIP**Street Address **6840 W. TOUHY**City / State / Zip Code **NILES, IL 60648**Phone Number **(847) 647-8994**Fax Number **(847) 647-0500**

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT	1	1	\$ 72,343	\$ 0	1	\$ 72,343	1
2	32	INTEREST	DIRECT	1	1	47,632	0	1	47,632	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 119,975	\$		\$ 119,975	25

Facility Name & ID Number **FOREST VILLA**# **0025460** Report Period Beginning: **01/01/2000**Ending: **12/31/2000**

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number **FOREST VILLA**# **0025460** Report Period Beginning: **01/01/2000**Ending: **12/31/2000**

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number **FOREST VILLA**# **0025460** Report Period Beginning: **01/01/2000**Ending: **12/31/2000**

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$					\$	1
2	RELATED PARTY			MORTGAGE	\$25,035.00	09/01/93	2,350,000	421,682	06/01/02	0.085	47,632		2
3	6840 PARTNERSHIP												3
4													4
5													5
	Working Capital												
6	LASALLE NATIONAL BANK	X		LINE OF CREDIT	INTEREST							74,837	6
7													7
8													8
9	TOTAL Facility Related				\$25,035.00		\$ 2,350,000	\$ 421,682			\$ 122,469		9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$	14
15	TOTALS (line 9+line14)						\$ 2,350,000	\$ 421,682			\$ 122,469		15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Print Preview

Facility Name & ID Number **FOREST VILLA**# **0025460** Report Period Beginning: **01/01/2000** Ending: **12/31/2000****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	216,792	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	213,317	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(3,475)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	215,450	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	\$	211,975	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	1996	1997	1998	1999
	199,558	198,698	204,880	210,477	21,317
	8	9	10	11	12

FOR OFF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATIC \$	16

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 1999 TAX YEAR.

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Print Preview

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,000 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories

C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO

If so, please complete the following:

1. Total Amount Incurred: _____ **2. Number of Years Over Which it is Being Amortized:** _____

3. Current Period Amortization: _____ **4. Dates Incurred:** _____

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME	114,267	1982	\$ 132,061	1
2					2
3	TOTALS	114,267		\$ 132,061	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B

Show Pgs 12C and 12D

Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Page 12

Facility Name & ID Number FOREST VILLA

0025460

Report Period Beginning:

01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	related pty				\$	\$		\$	\$	\$	4
5	206		1982		2,514,661	71,847	35	71,847		1,305,221	5
6			1983		17,370	496	35	496		9,342	6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	SPRINKLER SYSTEM		1982		50,599		25			50,599	9
10	ELECTRIC		1983		5,625		10			5,625	10
11	IMPROVEMENT		1986		6,155	324	15	410	86	5,945	11
12	IMPROVEMENT		1986		90,650	4,771	25	3,626	(1,145)	52,577	12
13	IMPROVEMENT		1987		17,807	565	20	890	325	12,015	13
14	IMPROVEMENT		1988		19,400	1,145	15	1,145		15,419	14
15	IMPROVEMENT		1989		71,120	2,257	31.5	2,257		25,705	15
16	IMPROVEMENT		1990		29,270	929	31.5	929		9,694	16
17	IMPROVEMENT		1991		24,339	773	31.5	773		7,440	17
18	IMPROVEMENT		1992		8,400	267	31.5	267		2,337	18
19	IMPROVEMENT		1993		10,990	348	31.5	348		2,719	19
20	A/C HEATING CENTRAL UNIT		1994		5,100	131	39	131		876	20
21	FLOOR REPAIR		1994		2,195	56	39	56		357	21
22	WATER HEATER & PLUMBING		1995		3,640	93	39	93		516	22
23	ELEVATOR		1995		37,320	957	39	957		5,063	23
24	ELECTRICAL		1995		1,152	30	39	30		163	24
25	WATER HEATING & PLUMBING		1995		9,645	247	39	247		1,318	25
26	NEW DINING ROOM		1996		719,683	18,453	39	18,453		91,523	26
27	PATCH ROOF		1996		6,750	173	39	173		844	27
28	CUSTOM BUILT NURSE STATION		1996		6,914	177	39	177		863	28
29	SIGN		1996		748	19	39	19		88	29
30	CONSTRUCTION OF NEW WALLS		1996		10,780	276	39	276		1,277	30
31	FIRE DOORS		1996		7,630	196	39	196		906	31
32	SPRINKLER SYSTEM		1996		2,991	77	39	77		356	32
33	INSULATION WORK		1996		1,000	26	39	26		116	33
34	SHOWER ROOM REMODELING		1996		1,283	33	39	33		139	34
35	TOTAL FROM PAGE 12A+12B										
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
					\$ #VALUE!	\$ 104,666		\$ 103,932	\$ (734)	\$ 1,609,043	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12A

STATE OF ILLINOIS

Page 12A

Facility Name & ID Numbe FOREST VILLA

0025460

Report Period Beginning:

01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9		DIALYSIS STATION		1997	6,800	174	39	174		616	9
10		FIRE DOORS		1997	24,318	624	39	624		2,209	10
11		ROOM REHAB		1997	13,557	347	39	347		1,229	11
12		THERAPY ROOM REHAB		1997	22,346	573	39	573		2,029	12
13		ROOF TOP HEATER/AIR CONDITIONER		1997	11,500	295	39	295		1,045	13
14		ELECTRICAL WORK		1997	783	20	39	20		71	14
15		CUSTOM NURSE STATION		1997	10,976	281	39	281		995	15
16		BUILT-IN CABINETS THERAPY ROOM		1997	7,018	180	39	180		637	16
17		COOLING TOWER		1997	12,920	331	39	331		1,172	17
18		WINDOWS		1997	41,620	1,067	39	1,067		3,779	18
19		ROOF FACIA		1997	9,045	232	39	232		822	19
20		ALARM SYSTEM		1997	33,051	849	39	849		3,006	20
21		BATHROOM REMODELING		1998	145,938	3,741	39	3,741		10,756	21
22		ELECTRICAL WORK		1998	3,648	93	39	93		268	22
23		CORNER GUARDS		1998	417	11	39	11		31	23
24		DOOR		1998	1,770	45	39	45		118	24
25		KITCHEN SINK AND GREASE TRAP		1998	3,806	98	39	98		257	25
26		PHOTO ELECTRIC SMOKE DETECTORS		1998	3,080	79	39	79		207	26
27		PLUMBING WORK		1998	3,031	78	39	78		185	27
28		GARDEN WINDOW		1998	2,290	59	39	59		140	28
29		WINSTROM WINDOWS		1998	55,950	1,435	39	1,435		3,049	29
30		BOILER		1999	2,414	62	39	62		96	30
31		ROOF REPAIR		1999	8,000	205	39	205		316	31
32		SINKS & FAUCETS		1999	675	17	39	17		26	32
33		TILING		1999	14,313	367	39	367		566	33
34		DOOR		1999	2,260	58	39	58		89	34
35		TOILETS		1999	3,919	100	39	100		154	35
36		PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3			\$ #VALUE!	\$ 11,421		\$ 11,421	\$	\$ 33,868	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

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Facility Name & ID Numbe FOREST VILLA

0025460

Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	FIRE DOORS		1999		3,490	89	39	89		137	9
10	CUSTOM CABINETS		1999		10,672	274	39	274		422	10
11	DIALYSIS ROOM		1999		22,100	567	39	567		874	11
12	BOILER TUBE		1999		3,842	99	39	99		152	12
13	AWNINGS		1999		3,649	94	39	94		145	13
14	NURSE STATION		1999		5,985	153	39	153		236	14
15	VALVES, PUMPS		1999		6,243	160	39	160		247	15
16	CUSTOM CABINETS		1999		4,168	107	39	107		165	16
17	HOT WATER HEATER		1999		2,418	62	39	62		96	17
18	VENT		2000		2,945	58	27.5	58		58	18
19	DOOR		2000		1,780	35	27.5	35		35	19
20	AIRHANDLER COILS		2000		10,362	204	27.5	204		204	20
21	WATER HEATER		2000		18,703	369	27.5	369		369	21
22	WATER PUMP		2000		4,753	94	27.5	94		94	22
23	ELECTRICAL WORK		2000		6,216	122	27.5	122		122	23
24	ELECTRICAL WORK		2000		2,698	53	27.5	53		53	24
25	CORNICE		2000		2,195	314	10	110	(204)	110	25
26	DRAPES		2000		5,159	737	10	258	(479)	258	26
27	WALLCOVERINGS		2000		1,511	216	10	76	(140)	76	27
28	CARPET		2000		2,068	296	10	103	(193)	103	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$ 4,103		\$ 3,087	\$ (1,016)	\$ 3,956	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

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Report Period Beginning: 01/01/2000 Ending: 12/31/2000

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Facility Name & ID Numbe FOREST VILLA

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

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Facility Name & ID Numbe FOREST VILLA

0025460

Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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Facility Name & ID Number **FOREST VILLA**# **0025460**Report Period Beginning: **01/01/2000** Ending: **12/31/2000****XI. OWNERSHIP COSTS (continued)****C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componer Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 794,208	\$ 68,998	\$ 67,042	\$ (1,956)		\$ 490,633	37
38	Current Year Purchases	32,393	5,116	1,620	(3,496)	10 YRS	1,620	38
39	Fully Depreciated Assets	383,506				10 YRS	383,506	39
40	rel party-kaf		3,643	3,643				40
41	TOTALS	\$ 1,210,107	\$ 77,757	\$ 72,305	\$ (5,452)		\$ 875,759	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ #VALUE!	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 197,947	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 190,745	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ (7,202)	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 2,522,626	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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XII. RENTAL COSTS**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ 603,948			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ 603,948			7

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.9. Option to Buy: ☐ YES ☐ NO Terms: _____ ***B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO16. Rental Amount for movable equipm: \$ **28,815** Description: **SEE SCHEDULE ATTACHED**

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. **/2001** \$ _____13. **/2002** \$ _____14. **/2003** \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number FOREST VILLA# 0025460

Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**1. HAVE YOU TRAINED AIDES
DURING THIS REPORT
PERIOD?☐ YES☒ NOIf "yes", please complete the remainder
of this schedule. If "no", provide an
explanation as to why this training was
not necessary.**THE FACILITY HIRES ONLY TRAINED AIDES.**2. CLASSROOM PORTION:IN-HOUSE PROGRAM ☐IN OTHER FACILITY ☐COMMUNITY COLLEGE ☐

HOURS PER AIDE _____

3. CLINICAL PORTION:IN-HOUSE PROGRAM ☐IN OTHER FACILITY ☐

HOURS PER AIDE _____

B. EXPENSES**ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOMEIn the box below record the amount of income your
facility received training aides from other facilities\$ **D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for
your own aides must agree with Sch. V, line 13, col. 8.(f) Attach a schedule of the facility names and addresses
of those facilities for which you trained aides.**Print Preview**

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ies.

Facility Name & ID Number **FOREST VILLA**# **0025460** Report Period Beginning: **01/01/2000** Ending: **12/31/2000**

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
							1	Licensed Occupational Therapist		
2	Licensed Speech and Language Development Therapist		hrs			17,842			17,842	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			56,510			56,510	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				187,059		187,059	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	inhalation therapy, outside services Other (specify): medical supplies					(13,537)	17,176		(13,537) 17,176	13
14	TOTAL			\$		\$ 54,706	\$ 204,235		\$ 258,941	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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Facility Name & ID Number FOREST VILLA

0025460

Report Period Beginning: 01/01/2000

Ending:

12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 49,415	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,744,924		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	79,893		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,874,232	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,706,655		15
16	Equipment, at Historical Cost	1,239,171		16
17	Accumulated Depreciation (book methods)	(1,418,147)		17
18	Deferred Charges	1,566		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSITS			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,529,245	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,403,477	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 506,929	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	675,000		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	202,861		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,609		31
32	Accrued Real Estate Taxes(Sch.IX-B)	215,450		32
33	Accrued Interest Payable	5,344		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,607,193	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,607,193	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,796,284	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,403,477	\$	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,628,912	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,628,912	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	394,964	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(227,592)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 167,372	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,796,284	24 *

* This must agree with page 17, line 47.

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Facility Name & ID Number FOREST VILLA

0025460

Report Period Beginning: 01/01/2000

Ending:

12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,405,525	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,405,525	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	249,317	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 249,317	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Commissions	(8,329)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (8,329)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,646,513	30

2			
Expenses		Amount	
A. Operating Expenses			
31	General Services	\$ 1,535,653	31
32	Health Care	3,216,390	32
33	General Administration	2,079,452	33
B. Capital Expense			
34	Ownership	1,044,725	34
C. Ancillary Expense			
35	Special Cost Centers	258,941	35
36	Provider Participation Fee	116,388	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,251,549	40
41	Income before Income Taxes (line 30 minus line 40)**	394,964	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 394,964	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,941	2,091	\$ 69,532	\$ 33.25	1
2	Assistant Director of Nursing	6,238	6,674	151,700	22.73	2
3	Registered Nurses	30,785	33,923	667,108	19.67	3
4	Licensed Practical Nurses	14,407	15,134	273,326	18.06	4
5	Nurse Aides & Orderlies	115,511	121,391	1,259,597	10.38	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,038	4,261	144,941	34.02	8
9	Activity Director	1,989	2,171	30,525	14.06	9
10	Activity Assistants	11,921	12,796	119,586	9.35	10
11	Social Service Workers	17,812	18,969	199,939	10.54	11
12	Dietician					12
13	Food Service Supervisor	1,810	2,091	43,615	20.86	13
14	Head Cook	6,739	7,321	71,188	9.72	14
15	Cook Helpers/Assistants	25,412	26,745	186,234	6.96	15
16	Dishwashers					16
17	Maintenance Workers	7,799	8,236	133,453	16.20	17
18	Housekeepers	32,385	34,873	268,454	7.70	18
19	Laundry	10,041	10,726	74,616	6.96	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,280	11,848	114,697	9.68	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Home)	12,039	12,619	112,820	8.94	30
31	Medical Records	3,640	3,791	33,066	8.72	31
32	Other Health Care(specify)					32
33	Other(specify) Contract Nursing					33
34	TOTAL (lines 1 - 33)	315,787	335,660	\$ 3,954,397 *	\$ 11.78	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M	\$ 11,838	1-3	35
36	Medical Director	O	4,400	9-3	36
37	Medical Records Consultant	N	5,133	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	0	10-3	39
40	Physical Therapy Consultant	L	10,625	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	F	950	11-3	44
45	Social Service Consultant	E	4,351	12-3	45
46	Other(specify)	E			46
47	PSYCHO-SOCIAL CONSULT	S	0	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 37,297		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides		1,032	10-3	52
53	TOTAL (lines 50 - 52)		\$ 1,032		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
	ADMIN		\$	Workers' Compensation Insurance	\$ 40,657	IDPH License Fee	\$	
				Unemployment Compensation Insurance	19,075	Advertising: Employee Recruitment	25,162	
				FICA Taxes	296,726	Health Care Worker Background Check	0	
				Employee Health Insurance	66,966	(Indicate # of checks performed)		
				Employee Meals	0	ADV & PROMO/MARKETING	18,367	
				Illinois Municipal Retirement Fund (IMRF)*		DUES & SUBSCRIPTIONS	12,710	
				PENSION/PROFIT SHARING CONTRIB	4,349	LICENSES & PERMITS	12,236	
				EMPLOYEE BENEFITS-OTHER	9,038	TRUST FEES, CONTRIBUTIONS, etc.	4,000	
				EMPLOYEE PHYSICAL EXAMS	2,081	MGMT CO ALLOCATION	0	
				INSURANCE EXECUTIVE LIFE	0	LESS TRUST FEES, CONTRIB, etc.	(4,000)	
				CHICAGO HEAD TAX	0	Less: Public Relations Expense	()	
				RELATED PARTY	0	Non-allowable advertising	(18,367)	
				INSURANCE EXECUTIVE LIFE	0	Yellow page advertising	(0)	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 438,892	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 50,108	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.) \$				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
B. Administrative - Other				Description			Description	
Description				Line #			Amount	
FAMILY CARE MANAGEMENT LTD-MANAGEMENT							Out-of-State Travel	
\$ 832,628							\$	
TOTAL (agree to Schedule V, line 17, col. 3)							In-State Travel	
(\$ 832,628)							TRAVEL	
(Attach a copy of any management service agreement)							RELATED PARTY	
C. Professional Services								
Vendor/Payee							Seminar Expense	
Type							related party	
Amount								
\$								
SEE ATTACHED							Entertainment Expense	
106,196							()	
							(agree to Sch. V,	
							TOTAL line 24, col. 8)	
							\$ 1,645	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL				
(\$ 106,196)				\$				
(If total legal fees exceed \$2500 attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	PAINT/DECORATI	6/00	\$ 3,906	3 yrs	\$	\$	\$	\$ 651	\$ 1,302	\$ 1,302	\$ 651	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 3,906		\$	\$	\$	\$ 651	\$ 1,302	\$ 1,302	\$ 651	\$	\$

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